SERFF Tracking Number:	*TPCI-128327047*	*State:*	*Arkansas*
Filing Company:	*PHL Variable Insurance Company*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*OL4348.1*		
Project Name/Number:	*/*		

Filing at a Glance

Company: PHL Variable Insurance Company

Product Name: OL4348.1	SERFF Tr Num: TPCI-128327047	State: Arkansas
TOI: L09I Individual Life - Flexible Premium Adjustable Life	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: L09I.001 Single Life	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Scott Zweig, Joseph Bonfitto, Barbara Slater, Elizabeth Stevens, Colleen Lyons, Marlene Burghardt	Disposition Date: 05/09/2012
	Date Submitted: 05/03/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Form is being filed in our domicile state concurrent with this filing.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 05/09/2012
	State Status Changed: 05/09/2012
Deemer Date:	Created By: Elizabeth Stevens
Submitted By: Elizabeth Stevens	Corresponding Filing Tracking Number:

Filing Description:

For Approval Purposes

Form OL4348.1 - Simplified Universal Life Insurance Application

We are filing the above-referenced form for approval in your jurisdiction. The form is new and is filed in accordance with the applicable statutes and regulations of your jurisdiction. The form is laser printed, subject only to minor variations in

paper stock, color, fonts, duplexing, and positioning. The form will be effective on the date of approval and will be marketed to the general public.

The form is a Simplified Universal Life Insurance Application that we will use with Contract 08IUL and its Schedule Pages, form 08IULSP-1, approved by the Department on 07/25/08 under SERFF # TPCI-125722619 (State Tracking # 39600) as well as schedule pages 08IULSP-3, approved on 1/13/09 under SERFF # TPCI-125900129 (State Tracking # 41300). In addition to the customary pre-printing of the form for use by producers and applicants, the form may also be produced in an electronic format for use with applicants who provide the legally required consents. The electronically generated application signed by the applicant(s) will be identical in content to the filed form.

Please see the enclosed Statement of Variability for a description of the bracketing that appears in the form. We certify that any change or modification to a variable item in the submitted form shall be administered in a uniform, nondiscriminatory manner, and including any requirements for prior approval of a change or modification.

Any requisite fees and filing documents have been included.

Your attention to this submission is appreciated. Should you have any questions or comments regarding this filing, please contact me at (860) 403-5607, or by email at Barbara.Slater@Phoenixwm.com.

State Narrative:

Company and Contact

Filing Contact Information

Barbara Slater, Compliance Coordinator	barbara.slater@phoenixwm.com	
One American Row	860-403-5607 [Phone]	
Hartford, CT 06102	860-403-5296 [FAX]	

Filing Company Information

PHL Variable Insurance Company	CoCode: 93548	State of Domicile: Connecticut
One American Row	Group Code: 403	Company Type: Life Insurance and Annuities
Hartford, CT 06102	Group Name:	State ID Number:
(860) 403-5000 ext. [Phone]	FEIN Number: 06-1045829	

Filing Fees

SERFF Tracking Number:	*TPCI-128327047*	*State:*	*Arkansas*
Filing Company:	*PHL Variable Insurance Company*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*OL4348.1*		
Project Name/Number:	*/*		

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	One form submitted @ $50 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
PHL Variable Insurance Company	$50.00	05/03/2012	58899038

SERFF Tracking Number:	*TPCI-128327047*	*State:*	*Arkansas*
Filing Company:	*PHL Variable Insurance Company*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*OL4348.1*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/09/2012	05/09/2012

SERFF Tracking Number:	*TPCI-128327047*	*State:*	*Arkansas*
Filing Company:	*PHL Variable Insurance Company*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*OL4348.1*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 05/09/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*TPCI-128327047*	*State:*	*Arkansas*
Filing Company:	*PHL Variable Insurance Company*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*OL4348.1*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	Statement of Variability		Yes
Form	Simplified Universal Life Insurance Application		Yes

SERFF Tracking Number:	*TPCI-128327047*	*State:*	*Arkansas*
Filing Company:	*PHL Variable Insurance Company*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*OL4348.1*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: OL4348.1

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	OL4348.1	Application/ Enrollment Form	Simplified Universal Life Insurance Application	Initial		55.290	OL4348.1 with john doe.pdf

PHOENIX®

PHL Variable Insurance Company (Phoenix)
Regular Mail: [PO Box 8027, Boston MA 02266-8027]
Overnight Mail: [30 Dan Rd., Suite 8027, Canton MA 02021-2809]

Simplified Universal Life Insurance Application

Print and use black ink. Any changes must be initialed by the Proposed Insured(s) and Owner.

Section 1 - Proposed Insured Information

Name (First, Middle, Last)	Sex	Date of Birth (mm/dd/yyyy)	Social Security Number/Tax ID
John A. Doe	☒ M ☐ F	10/15/1965	123-45-6789

Marital Status (including Civil Union Partner)	Birth State	Birth Country	U.S. Citizen
☐ Single ☒ Married ☐ Widowed ☐ Divorced	CT	USA	☒ Yes ☐ No [If "No", complete Non U.S. Citizen ONLY questions.]

Non U.S. Citizen ONLY	Country of Citizenship	Green Card / Visa Type	Expiration Date (mm/dd/yyyy)	Country of Permanent Residence	Social Security Number/Tax ID	Years in U.S.

Driver's License #	State	Earned Income	Unearned Income	Net Worth
0201-259-55885	CT	$ 100,000	$	$ 100,000

Residence Street Address (include Apt #)	City	State	ZIP Code
1 State Street	Anytown	CT	11256

Home Phone #	Work Phone #	Cellular Phone #	Best # to reach Insured
(860) 555 - 1212	(860) 444 - 1212	(860) 333 - 1212	☐ Home ☐ Work ☒ Cellular

Occupation	Current Employer	Years of Service	Email Address
Sales	Eastman Corporation	8	john.doe@email.com

Employer Street Address	City	State	ZIP Code	Employer's Phone #
123 American Avenue	Hometown	CT	11225	(860) 565 - 1212

During the past 5 years has the Proposed Insured used any form of tobacco or nicotine replacement therapy? . . . . . ☐ Yes ☒ No

Section 2 - Ownership

Select one, if B is elected, complete the following. If neither is selected, the Insured will be designated to be the Owner.

☒ A. Proposed Insured ☐ B. Other (If Owner is a Trust please complete [Certification of Trust Agreement - OL4132])

Primary Owner's Name (First, Middle, Last)	Social Security Number/Tax ID	Date of Birth (mm/dd/yyyy)	Relationship to Proposed Insured

Primary Owner's Street Address (include Apt #)	City	State	ZIP Code	Home Telephone #
				( )

Email Address

Section 3 - Beneficiary Designation

Unless otherwise specified, payments will be shared equally by all surviving primary beneficiaries, or if none, by all surviving contingent beneficiaries.

Only the owner has the right to change the beneficiaries unless otherwise stated.

Beneficiary Name (First, Middle, Last)	Beneficiary Designation **Check one each beneficiary.** If nothing checked, the designation will be Primary	Relationship to Proposed Insured **Check one each beneficiary.**	Date of Birth (mm/dd/yyyy)	Social Security or Tax ID Number	Percent %
Mary Doe	☒ Primary ☐ Contingent	☐ Federal Spouse ☐ Civil Union Partner ☐ Child ☐ Trust - Date of Trust _____ ☒ Other Mother	04/02/1957	345-67-8912	100
	☐ Primary ☐ Contingent	☐ Federal Spouse ☐ Civil Union Partner ☐ Child ☐ Trust - Date of Trust _____ ☐ Other _____			

Section 4 - Coverage Applied For

☒ **Phoenix Simplicity Index Life**

Face Amount $ 150,000

Death Benefit Option: Check one: (If none checked, Option A will apply.)

☐ Option A: Level ☒ Option B: Increasing

Product Riders/Features

☒ Monthly Transfer Strategy

Section 5 - Premium Allocation

All requests must be in whole percentages and total allocation **MUST** equal 100%)

☒ Fixed Account	100 %
☐ Indexed Account A – Annual Point-to-Point with CAP	%
☐ Indexed Account B – Annual Point-to-Point with Participation Rate	%
☐ Other	%
TOTAL	100%

Acknowledgements Relating to Indexed Universal Life Insurance

By selecting this Plan of Insurance, I understand the following:

- I am applying for an indexed universal life insurance product, which includes a Fixed Account and one or more Indexed Accounts. While Policy Value for each Indexed Account is affected by the value of an outside index, the policy does not directly participate in any stock, bond or equity investment.
- Premiums are initially applied to the Fixed Account and will not be transferred to the Indexed Account(s) until the next eligible Transfer Date and Premium Allocation election(s) can be made by written request to Phoenix.
- Index Credits, if any, are not credited to the Indexed Account until the Segment Maturity Date.

Section 6 - Screening Questions

IF THE PROPOSED INSURED ANSWERED "YES" TO ANY PART OF QUESTIONS 1-3 BELOW, COVERAGE IS NOT AVAILABLE UNDER THIS PLAN AND THE APPLICATION SHOULD NOT BE COMPLETED OR SUBMITTED.

To the best of your knowledge and belief:

1. Have you been diagnosed, treated, tested positive for or been given medical advise by a physician or other health care provider for; Alzheimer's disease, chest pain, dementia, demyelinating disease (other than multiple sclerosis), Downs syndrome, heart disease, Huntington's disease, leukemia, multiple myeloma, organ transplant, Parkinson's disease, stroke, schizophrenia? ☐ Yes ☒ No

2a. In the last 10 years have you received counseling or medical treatment for alcoholism, alcohol abuse or other drug use? ☐ Yes ☒ No

2b. In the last 10 years have you used amphetamines, barbiturates, cocaine, hallucinogens, marijuana, narcotics or any other drug except as legally prescribed by a health care provider?. ☐ Yes ☒ No

3. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☒ No

Section 7 - Mode of Premium Payment

Pay Mode ☐ Phoenix Check-O-Matic (monthly bank draft) ☒ Annual ☐ Semi-Annual ☐ Quarterly

Amount paid with Application $ _____
(or amount requested for initial premium draft)

Initial Premium to be paid by: ☐ Check (submit check with application) ☐ Bank Draft (the bank draft option is only available for the Check-O-Matic pay mode)

Authorization Agreement for Initial and Subsequent Premium Bank Draft

I (we) hereby authorize PHL Variable Insurance Company to initiate debit entries to my (our) checking account at the financial institution as shown on the attached voided check below.

I (we) hereby authorize PHL Variable Insurance Company to initiate debit entries to my (our) checking account for the initial premium amount stated above and I (we) request that the monthly recurring premium drafts occur on the _____ date of the month.

NOTE: You may select any date between the first and the 28th of the month.

Signature of Depositor (if different from Owner(s)) _____

Print Depositor Name (First, Middle, Last) _____ Relationship to Owner(s) _____

Include Required Voided Check

Continued on next page.

Section 7 - Mode of Premium Payment - continued

Send additional premium notices to:

Name (First, Middle, Last) _____

Street Address _____

City _____ State _____ ZIP Code _____ Relationship to Owner(s) _____

Section 8 - Insurance History

1a. With this policy, do you plan to replace (in whole or in part, now or in the future) any existing insurance or annuity in force? . . . . . ☐ Yes ☒ No

1b. Are there any life insurance policies or annuity contracts, owned by, or on the life of, the applicant(s), or the insured(s) or the owner(s) or the annuitant? . . . . . ☐ Yes ☒ No

1c. Do you plan to utilize values from any existing life insurance policy or annuity contract (through loans, surrenders or otherwise) to pay any initial or subsequent premium(s) for this policy? . . . . . ☐ Yes ☒ No

2. Have you ever applied for life, accident, disability or health insurance and been declined, postponed, or been offered a policy differing in plan, amount or premium rate from that applied for? (If "Yes", provide date, company and reason). . . . . ☐ Yes ☒ No

Date (mm/dd/yyyy): Company: Reason:

3. Are you negotiating for other insurance? (If "Yes", name companies, date, outcome and total amount to be placed in force). . . . . ☐ Yes ☒ No

Company(ies): Total Amount to be placed in force:

Complete grid for all in force coverage.

Company	Insurance Personal	Insurance Business	Issue Date mm/yyyy	Replacing? Yes	Replacing? No	Amount Including Riders	Indicate if Sold, Assigned, Transferred or Settled and Date
	☐	☐		☐	☐	$	
	☐	☐		☐	☐	$	

Section 9 - Medical History

Provide full details for all "Yes" answers below. Use Section 11 - Additional Information to record additional details.

Personal Physician or Health Care Provider Name *(if None, please indicate):*	Telephone # ( )
Street Address, City, State, ZIP Code	

Most Recent Visit Date (mm/dd/yyyy)	Reason for Visit	Results of Treatment (if any)	Height	Weight

To the best of your knowledge and belief:

1. Have you gained or lost 10 pounds or more in the past 2 years? . . . . . ☐ Yes ☒ No
   If "Yes", how many _____ pounds ☐ Gain ☐ Loss
   Reason_____

2a. Have you been treated by a physician or other care provider, been a patient in any hospital, emergency room, treatment center, urgent care or similar facility for any reason in the last 5 years? . . . . . ☐ Yes ☒ No
   If "Yes", provide **details** below.

2b. In the past 5 years, have you had any diagnostic testing (excluding HIV) or have you been scheduled or advised to have any diagnostic tests or surgery not yet performed? . . . . . ☐ Yes ☒ No

3. In the past two years, have you been prescribed medications? . . . . . ☐ Yes ☒ No
   If "Yes", provide **details** below.

Medication Prescribed	Frequency and Dosage	Dates Medication Taken (from: mm/yy to: mm/yy)	Condition Treated

Continued on next page.

Section 9 - Medical History - *continued*

4. To the best of your knowledge and belief, have you been diagnosed, treated, tested positive for or been given medical advice by a physician or other health care provider for arrhythmia, asthma, bipolar disease, brain or neurological disease, cancer, connective tissue disease, diabetes, depression, emphysema, gastrointestinal disease, high blood pressure, immunological disease (excluding Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome), kidney disease, liver disease, lung disorder, mental or nervous disorder, multiple sclerosis, paralysis, peripheral vascular disease, rheumatoid arthritis, transient ischemic attack, tumor? . . . . . ☐ Yes ☒ No
   If "Yes", provide details. **Details:**

5. Have you ever been diagnosed or treated by a member of the medical profession for specified symptoms such as; anemia, Carinii Pneumonia, diarrhea, fatigue or unexplained weight loss, fever of unknown origin, immune deficiency, Kaposi's Sarcoma or Pneumocystis, loss of appetite, malaise, recurrent fever, severe night sweats, skin lesions, unexplained swelling of the lymph glands, unexplained or unusual infections? . . . . . ☐ Yes ☒ No
   If "Yes", provide details. **Details:**

Additional Medical History. Applicants older than 65 years answers questions below:

6. Are you using any of the following: cane, catheter, electric scooter, oxygen, walker or wheelchair? . . . . . ☐ Yes ☒ No
   If "Yes", provide details. **Details:**

7. In the past year, have you required the assistance of another person for: bathing, dressing, eating, toileting, transferring, or the management of bowel or bladder problems? . . . . . ☐ Yes ☒ No
   If "Yes", provide details. **Details:**

8. In the past year, have you had any falls, received or been advised to have any of the following: care in an adult day care facility, assisted living facility, home health care, nursing home care or physical, occupational or speech therapy? . . . . . ☐ Yes ☒ No
   If "Yes", provide details. **Details:**

Section 10 - Non - Medical Information

Provide full details for all "Yes" answers below. Use Section 11 - Additional Information to record additional details.

1a. Have you traveled or resided in the past 2 years outside of the United States or Canada? . . . . . ☐ Yes ☒ No

1b. Do you plan to do so within the next 2 years? (If "Yes", state where, how long and purpose.) . . . . . ☐ Yes ☒ No
   Location City, Country: Purpose: How Long: (Specify weeks, months, years)

2a. Have you flown during the past 3 years as a pilot, student pilot or crew member?
   (If "Yes", complete [Aviation Application Supplement.]) . . . . . ☐ Yes ☒ No

2b. Do you plan to do so within the next 2 years? (If "Yes", complete [Aviation Application Supplement.]) . . . . . ☐ Yes ☒ No

3a. Have you participated in the past 3 years in ATV (all-terrain vehicle), motorized vehicle racing, stunt driving, motorcycle, motorboat, horse, or truck racing, rodeo, jet ski, scuba/skin diving, spelunking (cave exploration), heleskiing, hang gliding, cliff diving, bungee jumping, snowmobile, bobsled, skeleton, luge, skydiving/sport parachuting, ultralight flying, ballooning, mountain climbing, big game hunting, boxing, martial arts? (If "Yes", complete [Avocation Questionnaire.]) . . . . . ☐ Yes ☒ No

3b. Do you plan to do so within the next 2 years? (If "Yes", complete [Avocation Questionnaire.]) . . . . . ☐ Yes ☒ No

4a. Have you ever been arrested for, convicted of, or pled guilty to any felony or misdemeanor (other than a minor traffic violation)? . . . . . ☐ Yes ☒ No
   If "Yes", provide details. **Details**:

4b. Are you currently or ever been on probation or parole? . . . . . ☐ Yes ☒ No
   If "Yes", provide details. **Details**:

5. Have you ever been convicted of driving under the influence of alcohol or drugs, or had your driver's license been suspended or revoked, or had greater than 2 moving violations in the past 3 years? . . . . . ☐ Yes ☒ No
   If "Yes", provide details including violations and dates. **Details:**

6. Have you ever filed bankruptcy? . . . . . ☐ Yes ☒ No
   If "Yes", provide types, reason, date filed and date discharged. **Details:**

Section 11 - Additional Information

Use space below to record all additional information.

Section # _____ Question # _____ **Details:**

Section # _____ Question # _____ **Details:**

Section # _____ Question # _____ **Details:**

Section # _____ Question # _____ **Details:**

Section 12 - Authorization To Obtain Information

I authorize any licensed physician, health care practitioner, hospital, medical laboratory, pharmacy or pharmacy benefit manager, clinic or other medically-related facility, insurance company or MIB (formerly Medical Information Bureau), having any records or knowledge of me or my health or prescription history to provide any such information to Phoenix, its affiliates, service providers or its reinsurers. The information requested may include information regarding diagnosis and treatment of physical or mental condition, including consultations occurring after the date this authorization is signed. I authorize any of the above sources to release to Phoenix, its affiliates, service providers or its reinsurers any of my information relating to alcohol use, drug use and mental health care. Further, I authorize Phoenix, its affiliates, service providers or its reinsurers to make a brief report of my personal health information to MIB.

I authorize consumer reporting agencies, insurance companies, motor vehicle departments, my attorneys, accountants and business associates, pharmacy or pharmacy benefit manager, and MIB to provide any information to Phoenix, its affiliates, service providers or its reinsurers that may affect my insurability. This may include information about my medical history, occupation, participation in hazardous activities, motor vehicle record, foreign travel, finances, insurance history or other personal information.

Any information will be used only for the purpose of risk evaluation and determining eligibility for benefits under any policies issued. Phoenix, its affiliates or service providers may disclose information it has obtained to others as permitted or required by law, including MIB, our reinsurers and other persons or entities performing business or legal services in connection with this application, any contract issued pursuant to it or in connection with the determination of eligibility for benefits under an existing policy. Information that is not personally identifiable may be used for insurance statistical studies.

To facilitate rapid submission of information, I authorize all of the above sources, except MIB, to give such records or knowledge to any agent, agency or producer authorized to do business with Phoenix its affiliates or service providers to collect and transmit such information.

I acknowledge that I have received a copy of the Notice of Information Practices, including information about Investigative Consumer Reports and MIB. I authorize the preparation of an investigative consumer report. I understand that upon written request, I am entitled to receive a copy of the investigative consumer report.

This authorization shall continue to be valid for 30 months (24 months for North Dakota) from the date it is signed unless otherwise required by law. A copy of this signed authorization shall be as valid as the original. This authorization may be revoked by writing to Phoenix prior to the time the insurance coverage has been placed in force. I understand my authorized representative or I may receive a copy of this authorization on request.

☐ **I do** ☒ **I do not** (check one) require that I be interviewed in connection with any investigative consumer report that may be prepared.

Section 13 - Signature

I have reviewed this Application and all of the statements made herein are those of the Proposed Insured and all such statements have been correctly recorded and are full, complete and true to the best of the Proposed Insured's knowledge and belief.

I understand that the Company will rely upon the information provided in this Application and the statements and answers in the application are the basis for any policy issued by Phoenix. No information about them will be considered to have been given to Phoenix unless it is stated in the application.

I understand that 1) no statements made to or information acquired by any Licensed Producer who takes this Application shall bind Phoenix unless stated in this Application, (not applicable in ND and SD) and 2) no Licensed Producer has authority to make, modify, alter or discharge any contract thereby applied for.

I understand that if there is any change in health or personal history that would alter the answers to any of the questions in the application between now and when the policy is delivered, I will inform Phoenix in writing as soon as possible at PO Box 8027, Boston, MA 02266-8027.

I understand and agree that the insurance applied for shall not take effect unless each of the following has occurred:

1) the policy has been issued by Phoenix;
2) the premium required for issuance of the policy has been paid in full during the lifetime of the Insured;
3) all representations made in the application remain true, complete and accurate as of the date the policy is delivered;
4) the Insured are alive when the policy is delivered;
5) as of the date of delivery of the policy, there has been no change in the health or personal history of any Insured that would alter the answers to any of the questions in the Application; and
6) any required forms, including the delivery receipt, are signed and returned to us.

If applicable, I confirm that I have received a copy of the disclosure form, summary of Coverage of Death Benefit Rider, for the Acceleration of Death Benefit Rider.

Under penalty of perjury, I confirm that 1) the Social Security or Tax Identification Number shown is correct, and 2) that I am not subject to back-up withholding.

If I am an Owner who is not the Proposed Insured, I join in the foregoing affirmations, acknowledgments and undertakings of the proposed insured. In addition, the statements made by me in any part of this application are full, complete and true to the best of my knowledge and belief and have been correctly recorded.

I understand that unless this contract is obtained solely with the proceeds from a prior life insurance contract, which was not a modified endowments contract (MEC), this contract will be classified as a modified endowment contract (MEC) under the Internal Revenue Code and that any loans or distributions may be taxable when taken.

Proposed Insured's Signature	**State Signed In**	Date (mm/dd/yyyy)
John A Doe	CT	04/30/2012
Owner's Signature	**State Signed In**	Date (mm/dd/yyyy)
Jane A Doe	CT	04/30/2012
Owner's Signature	**State Signed In**	Date (mm/dd/yyyy)

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of competent jurisdiction.

In AR any person who knowingly presents a false or fraudulent claim for payments of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

In DC, WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON, PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, ANY INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

The Producer hereby confirms he/she has truly and accurately recorded on the application the information supplied by the Proposed Insured; is not aware of any decrepancies or misrepresentation in the recorded information; and that he/she is qualified and authorized to discuss the contract herein applied for.

Licensed Producer's Name (Print First, Middle, Last)	Licensed Producer's Email Address	Phoenix Producer I.D. #	Licensed Producer's Telephone #	Licensed Producer's Signature	Date (mm/dd/yyyy)
Bill A. Producer	Bill.Producer@ phoenix.com	12-56598-2001	(860) 403 – 0000	Bill A Producer	04/30/2012
			( ) –		

SERFF Tracking Number:	*TPCI-128327047*	*State:*	*Arkansas*
Filing Company:	*PHL Variable Insurance Company*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*OL4348.1*		
Project Name/Number:	*/*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
AR certifications - OL4348.1.pdf

Item Status: **Status Date:**

Satisfied - Item: Application
Comments:
The form being filed is an application. Please see Forms tab.

Item Status: **Status Date:**

Bypassed - Item: Health - Actuarial Justification
Bypass Reason: Not applicable.
Comments:

Item Status: **Status Date:**

Bypassed - Item: Outline of Coverage
Bypass Reason: Not applicable.
Comments:

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability
Comments:
Attachment:
OL4348.1 - Statement of Variability.pdf

ARKANSAS
CERTIFICATION

FORM NO.	**OL4348.1**
FORM TITLE	**Simplified Universal Life Insurance Application**
FLESCH SCORE	**55.29**

I hereby certify the following:

- To the best of my knowledge and belief, the above form(s) and submission comply with Reg. 19 and Reg. 49, as well as the other laws and regulations of the State of Arkansas.

- The attached forms comply with ACA 23-79-138 and Bulletin 11-88.

PHL Variable Insurance Company

Signature: Scott Zweig

Name: **Scott Zweig**
Title: **Director, State Compliance**
Date: **May 2, 2012**

Statement of Variability – Simplified Universal Life Insurance Application

This Statement of Variability sets forth the variable information which will appear in brackets in form OL4348.1 (Simplified Universal Life Insurance Application.) No change in variability will be made which in any way expands the scope of the wording being changed.

OL4348.1, Page 1

Company Logo:

The company logo has been bracketed to indicate that this logo could be changed in the future

Company Addresses:

Each address has been bracketed to indicate that it may either change or an additional address may be added in the future.

Section 1 – Proposed Insured Information:

The language under "U.S. Citizen" has been bracketed to indicate that it may be deleted in the future. If this information is no longer required, it will be deleted on a non-discriminatory basis and regardless of the product applied for.

"Non U.S. Citizen Only" has been bracketed to indicate that it may be deleted in the future. If this information is no longer required, it will be deleted on a non-discriminatory basis and regardless of the product applied for.

Section 2 – Ownership:

Certificate of Trust Agreement – OL4132 – The form name and number has been bracketed to indicate that it may either change or an additional form reference may be added in the future.

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Section 4 – Coverage Applied For:

The available plan is bracketed to indicate that one or more of the options may be deleted and not offered, that additional options may be added, and/or the plan names may change. If additional plans are offered they will be offered for new issues only and on a uniform non-discriminatory basis.

Section 5 – Premium Allocation:

The bracketing of the check boxes and text in this section indicates that if these options are no longer offered, they will not appear on this form. It is also bracketed to indicate that additional options may be added in the future.

Section 7 – Mode of Premium Payment:

The different payment options have been bracketed to indicate that either all of the options shown here may not be available, or that additional payment options may be added. If any of the payment options listed are available the text that appears will be identical to the text that appears on the form.